	A	DA Dental Cla	aim	For	m										
	Н	EADER INFORMATION							1	~ .		DO DOV 051017 I	P.O. BOX 851917, Richardson, TX 75085		
	1. Type of Transaction (Mark all applicable boxes)								Dental <u>Select</u> P.O. BOX 851917, Richar (801) 495-3000 Fax (80						
		Statement of Actual Ser	rvices	[Request for Prede	terminatio	n/Preauthorizati	ion			Toll Free (800) 999				
	EPSDT/Title XIX								dentalselect.com						
	2.	Predetermination/Preautho	rization	Number					POLICYHOLDER/SUB	SCRIBE	R INFORM	MATION (For Insurar	ice Company N	lamed in #3)	
									12. Policyholder/Subscribe						
	ΙN	SURANCE COMPANY/	DENTA	L BEN	EFIT PLAN INFOR	MATION	1		1			. ,			
	3.	Company/Plan Name, Addre	ess, City	, State, 2	Zip Code										
									13. Date of Birth (MM/DD/C	CCYYI	14. Gend	er 15 Policyhol	der/Subscriber ID	(SSN or ID#)	
									,	,		∏F I	30.7033301130.713	(00110111511)	
	0	THER COVERAGE							16. Plan/Group Number		17. Employe				
	4.	Other Dental or Medical Cov	verage?		No (Skip 5-11)	Yes	(Complete 5-11)		1	l					
	5.	Name of Policyholder/Subsc	criber in	#4 (Last	t, First, Middle Initial, S	uffix)	*		PATIENT INFORMATION	N N					
		·			·		18. Relationship to Policyh		scriber in #1	2 Ahove	19. Student	Status			
—₽	6.	Date of Birth (MM/DD/CCY)	Y)	7. Gend	der 8. Policyh	nolder/Sub	scriber ID (SSN	or ID#)	Self Spou	_	Dependen	_	FTS	PTS	
			.	М			•	,	20. Name (Last, First, Midd				, <u> </u>		
	9.	Plan/Group Number		10. Pati	ent's Relationship to F	erson Na	med in #5				, , , , , , , , , , , , , , , , , , ,	033, Oily, Ollate, Zip 000	16		
		·		s	elf Spouse	Dep	endent 0)ther							
	11	. Other Insurance Company/	/Dental I	Benefit P	Plan Name, Address, C					,					
						•	,								
									21. Date of Birth (MM/DD/C	C(YY)	22. Gende	er 23. Patient ID.	/Account # (Assig	ned by Dentist)	
									, , , , , , , , , , , , , , , , , , , ,	,	М	□F	Triboodin ir (ribbig	mod by Bernisty	
	RI	ECORD OF SERVICES	PROVI	DED					d						
	П	24. Procedure Date	25. Area	26.	27. Tooth Numb	er(e)	28. Tooth	29. Proced	ura	-					
		(MM/DD/CCYY)	of Ora Cavity	Tooth System	or Letter(s)	er(s)	Surface	Code	ule		30. Descri	ption		31. Fee	
	1													:	
	2		i											1	
	3														
	4			1											
	5						· · · · · · · · · · · · · · · · · · ·							- - 	
	6								· · · · · · · · · · · · · · · · · · ·			·			
	7														
	8		-				<u> </u>	-						 	
	9	- · · · · · · · · · · · · · · · · · · ·				*****					***************************************				
	10	-turbus actions													
	Mi	ISSING TEETH INFORM	IATION	1			Permanent				Primary	,	1		
				1	2 3 4 5	6 7		11 12	13 14 15 16 A E	3 C I	D E F	77711	32. Other Fee(s)		
	34.	. (Place an 'X' on each missi	ng tooth	32	31 30 29 28	27 26			20 19 18 17 T S		Q P C		33.Total Fee	1 1	
Plo	35.	. Remarks				***************************************			- Land						
i	ΑI	UTHORIZATIONS							ANCILLARY CLAIM/TI	REATME	NT INFO	RMATION	-		
	36	i. I have been informed of the	e treatm	ent plan	and associated lees. I	agree to b	oe responsible fo	or all	38. Place of Treatment				ber of Enclosure:	s (00 to 99)	
į	the	arges for dental services and e treating dentist or dental pr	actice h	as a con	tractual agreement wit	h my plan	prohibiting all or	r a portion of	38. Place of Treatment 39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s) Provider's Office Hospital ECF Other						
1	su	such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.							40. Is Treatment for Orthodontics? 41. Date Appliance Placed (MM/DD/CCYY)						
	.,							No (Skip 41-42) Yes (Complete 41-42)							
	Pa	itient/Guardian signature				Dai	te	·	42. Months of Treatment	43. Replac	ement of Pr	rosthesis? 44. Date P	rior Placement (N	M/DD/CCYY)	
	07	I becale a subsection and alternation		- (4	tal basselia albassida sa				Remaining	No	Yes (Con	oplete 44)	,	·	
		 I hereby authorize and direct p entist or dental entity. 	ayment	or the der	itai benelits otherwise pa	yable to me	e, directly to the be	elow named	45. Treatment Resulting fro	m		· · · · · · · · · · · · · · · · · · ·			
	.,								Occupational illness	s/injury		Auto accident	Other accident	:	
	X_ Su	ubscriber signature				Dai	te		46. Date of Accident (MM/D				47. Auto Acciden		
		LLING DENTIST OR DE	ΝΤΔΙ	ENTITY	Y (Leave blank if deat			ıbmitting	TREATING DENTIST A	<u>·</u>	ATMENT	LOCATION INFORM			
		im on behalf of the patient of					an onliny to not be	2011111119	53. I hereby certify that the p	rocedures				require multiple	
	48.	. Name, Address, City, State,	, Zip Co	de					visits) or háve beén complete	ed.				,	
		•							V						
									X Signed (Treating Dentist)				Date		
						•			54. NPI			55. License Number			
									56. Address, City, State, Zi	p Code	<u>-</u>	56A. Provider Specialty Code			
	49	. NPI	50.	License	Number	51. SSN	or TIN		, ,, =, - ,			Specialty Code			
	52	Phone ()			52A. Additio	nal			57. Phone	***		58. Additional			
		Number ()			Provide	עווו	-		Number ()			Provider ID			

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1. FRAUD WARNINGS

Before completing this form, please read the following fraud warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, Minnesota, New Mexico, Ohio, Rhode Island, and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Idaho, Indiana, and Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Florida: A person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Virginia, and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Oregon and Vermont: Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

ADA.

American Dental Association www.ada.org

INSTRUCTIONS

Comprehensive completion instructions for the ADA Dental Claim Form are found in Section 4 of the ADA Publication titled CDT-2007/2008. Five relevant extracts from that section follow:

GENERAL INSTRUCTIONS

- A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #10 window envelope. Please fold the form using the 'tick-marks' printed in the margin.
- B. In the upper-right of the form, a blank space is provided for the convenience of the payer or insurance company, to allow the assignment of a claim or control number.
- C. All Items in the form must be completed unless it is noted on the form or in the following instructions that completion is not required.
- D. When a name and address field is required, the full name of an individual or a full business name, address and zip code must be entered.
- E. All dates must include the four-digit year.
- F. If the number of procedures reported exceeds the number of lines available on one claim form, the remaining procedures must be listed on a separate, fully completed claim form.

COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the form in its entirety and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may indicate the amount the primary carrier paid in the "Remarks" field (Item # 35).

NATIONAL PROVIDER IDENTIFIER (NPI)

49 and 54 NPI (National Provider Indentifier): This is an identifier assigned by the Federal government to all providers considered to be HIPAA covered entities. Dentists who are not covered entities may elect to obtain an NPI at their discretion, or may be enumerated if required by a participating provider agreement with a third-party payer or applicable state law/regulation. An NPI is unique to an individual dentist (Type 1 NPI) or dental entity (Type 2 NPI), and has no intrinsic meaning. Additional information on NPI and enumeration can be obtained from the ADA's Internet Web Site: www.ada.org/goto/npi

ADDITIONAL PROVIDER IDENTIFIER

52A and 58 Additional Provider ID: This is an identifier assigned to the billing dentist or dental entity other than a Social Security Number (SSN) or Tax Identification Number (TIN). It is not the provider's NPI. The additional identifier is sometimes referred to as a Legacy Identifier (LID). LIDs may not be unique as they are assigned by different entities (e.g., third-party payer; Federal government). Some Legacy IDs have an intrinsic meaning.

PROVIDER SPECIALTY CODES

56A <u>Provider Specialty Code</u>: Enter the code that indicates the type of dental professional who delivered the treatment. Available codes describing treating dentists are listed below. The general code listed as 'Dentist' may be used instead of any other dental practitioner code.

Category / Description Code	Code		
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X		
General Practice	1223G0001X		
Dental Specialty (see following list)	Various		
Dental Public Health	1223D0001X		
Endodontics	1223E0200X		
Orthodontics	1223X0400X		
Pediatric Dentistry	1223P0221X		
Periodontics	1223P0300X		
Prosthodontics	1223P0700X		
Oral & Maxillofacial Pathology	1223P0106X		
Oral & Maxillofacial Radiology	1223D0008X		
Oral & Maxillofacial Surgery	1223S0112X		

Dental provider taxonomy codes listed above are a subset of the full code set that is posted at: www.wpc-edi.com/codes/taxonomy

Should there be any updates to ADA Dental Claim Form completion instructions, the updates will be posted on the ADA's web site at: www.ada.org/goto/dentalcode